symptoms after onset is rapid; medical attention tends to be sought shortly after onset of such symptoms and, frequently, a previous history of psychiatric disturbance exists. Patients tend not to conceal but to emphasize their disability, and there is often early and prominent loss of social skills. Preservation of attention and concentration is common, disturbance in remote memory is often as severe as that for recent memory and patients tend to give "don't know" answers rather than near-miss responses.

It is important to rule out treatable metabolic or structural disease through careful physical examination and ancillary studies such as computed cerebral tomography. However, because enlarged cortical sulci and ventricular dilatation on computed tomographic (CT) scans do not necessarily imply the existence of dementing illness, the recognition of pseudodementia in the presence of cerebral atrophy must be made on clinical grounds. In this process, psychometric evaluation, including neuropsychological assessment, may be invaluable. Equally important, an accurate psychiatric diagnosis must be established to effect appropriate treatment interventions.

EDWARD H. LISTON, MD

REFERENCES

Wells CE: Pseudodementia. Am J Psychiatry 136:895-900, Jul 1979

Jarvik LF, Ruth V, Matsuyama SS: Organic brain syndrome and aging—A six-year follow-up of surviving twins. Arch Gen Psychiatry 37:280-286, Mar 1980

Besdine RW, Brody JA, Butler RN, et al: Senility reconsidered: Treatment possibilities for mental impairment in the elderly. JAMA 244:259-263, Jul 18, 1980

The Therapeutic Alliance and the Outcome of Psychotherapy

THE IMPORTANCE OF establishing and maintaining a therapeutic alliance in psychotherapy has been a subject of intense clinical interest since Freud's early attempts to define the treatment relationship. The therapeutic alliance has meant an attitude of positive regard between a patient and therapist, the patient's experience of the therapist as supportive and helpful and a sense that the patient and therapist are working together to restore the patient's well-being. There is an agreement between them concerning the techniques and objectives of their collaboration.

The contribution of such a cooperative relationship to the success of psychotherapy is an accepted clinical dictum in diverse psychotherapeutic schools. What is novel, however, is a recent convergence of evidence among psychotherapy researchers to support this clinical lore. At the 1980 Society for Psychotherapy Research meetings in Asilomar, California, five research centers working independently in the United States and Canada reported carefully instituted and reliably rated use of the Therapeutic Alliance Scales. In each instance raters, who had no knowledge of the treatment outcomes, scored audiotapes or transcripts of selected early and late psychotherapy sessions. The ratings were predictive of outcome; a positive alliance was associated with success in psychotherapy and a poor alliance was related to persistent symptomatic distress and social functioning disturbances. In one study, the patient's contribution to the alliance was decisive. Further, ratings of early treatment hours were predictive of outcome, suggesting that by the third to fifth session an attitudinal-affective climate had been created in the therapist-patient relationship that was relatively stable and was a useful prognostic indicator.

These studies have implications for both the practice and evaluation of psychotherapy because they show agreement between hypothesis-generating, descriptive clinical reports and hypothesis-testing research studies. This research is being followed with interest by clinicians who, historically, have ignored scientific evaluations of psychotherapy as esoteric, irrelevant or incomprehensible in relation to the real-life dilemmas of treating patients. Additionally, because the quality of the therapeutic alliance established early in treatment is predictive of the outcome, cases could be monitored while therapy is in progress, thereby permitting therapists to introduce new strategies to counter negative trends and avert treatment failures.

CHARLES MARMAR, MD

REFERENCES

Greenson RR: The working alliance and the transference neurosis. Psychoanal Q 34:155-181, Apr 1965

Luborsky L: Helping alliances in psychotherapy, *In* Claghorn JL (Ed): Successful Psychotherapy: Proceedings of the 9th Annual Symposium, November 19-21, 1975, Texas Research Institute cf Mental Sciences. New York, Brunner/Mazel, 1976

Marziali E, Marmar C, Krupnick J: Therapeutic alliance scales: Their development and relationship to psychotherapy outcome. Am J Psychiatry, 1981 (In press)

Gomes-Schwartz B: Effective ingredients in psychotherapy: Prediction of outcome from process variables. J Consult Clin Psychol 46:1023-1035, Oct 1978

Cholinergic Hypersensitivity in Patients With Affective Disorders

CONSIDERABLE EVIDENCE INDICATES that depression may reflect increased central acetylcholine activity, relative to catecholaminergic or serotonergic activity, and that mania may be due to the converse mechanism. Most antidepressant drugs have anticholinergic or acetylcholine-sup-

pressant properties, and those drugs which can induce depression, such as reserpine, generally increase cholinergic activity. Supporting the possibility that acetylcholine is involved in the regulation of affect are observations that physostigmine, a centrally acting cholinesterase inhibitor that increases brain acetylcholine, (1) causes a rapid and dramatic antagonism of manic symptoms, as well as anergy and mild depression in patients with bipolar affective disorders, (2) antagonizes methylphenidate-induced euphoria and psychostimulation and (3) causes a severe depressed mood in marijuana-intoxicated normal subjects. Similarly, choline, an acetylcholine precursor, can cause increases in depression in patients with tardive dyskinesia.

In addition, evidence exists that patients with affective disorders may be relatively more sensitive than normal persons and patients with nonaffective disorders to such cholinergic agents as physostigmine and arecholine. While most people become anergic after receiving physostigmine, in normal volunteers a depressed mood develops infrequently after receiving physostigmine. However, depression often develops in patients with an affective component of their illness, such as manic, depressive and schizoaffective conditions, and in euthymic patients with a history of affective disorders after they have received physostigmine. Similarly, deanol, a presumed acetylcholine precursor, has been found to cause selectively the development of affective symptoms in patients with tardive dyskinesia who have had a past history of an affective disorder. Also, patients with affective disorders appear to be relatively more reactive to the anergic, inhibitory, negative-mood-inducing and emetic effects of physostigmine. Furthermore, rapid eye movement (REM) latency, an acetylcholine-sensitive sleep determination that measures the time from onset of sleep until onset of the first REM period, is more sensitive to being decreased by cholinergic agents in patients with affective disorders than in normal subjects.

Thus, acetylcholine may be involved directly or indirectly in the regulation of affect, and patients with affective disorders appear to be more sensitive to the effects of cholinomimetic drugs.

DAVID S. JANOWSKY, MD

REFERENCES

Janowsky DS, el-Yousef MK, Davis JM, et al: A cholinergic-adrenergic hypothesis of mania and depression. Lancet 1:632-635, Sep 23, 1972

Janowsky DS, el-Yousef MK, Davis JM: Acetylcholine and depression. Psychosom Med 36:248, May-Jun 1974

Davis KL, Berger PA, Hollister LE, et al: Physostigmine in mania. Arch Gen Psychiatry 35:119-122, Jan 1978

Sitaram N, Nurnberger JI, Gershon ES, et al: Faster cholinergic REM sleep induction in euthymic patients with primary affective illness. Science 208:200-202, Apr 11, 1980

Cognitive and Behavioral Psychotherapeutic Approaches to Depression

BEHAVIORAL AND COGNITIVE-BEHAVIORAL forms of treatment for nonbipolar, nonpsychotic outpatients suffering from depression focus on teaching them specific skills in a structured, time-limited context (usually in 12 to 20 sessions). Patients are given a rationale that describes the relationship between mood and behavioral or cognitive patterns; they are taught methods to alter these patterns in a manner that will decrease the probability of debilitating depression; they are instructed to practice their newly acquired skills outside the therapy sessions and they are encouraged to attribute the therapeutic change to their continued use of these skills in their everyday life. The theoretical effect of these techniques is to increase a patient's feelings of self-efficacy, to reduce feelings of hopelessness and helplessness and to avoid creating continued dependence on the therapist.

The directive nature of these therapies has lent itself to the development of manuals and texts that describe the treatment techniques in great detail. Beck and his colleagues at the University of Pennsylvania have developed and tested a cognitive-behavior therapy manual, which is now being evaluated in a major National Institute of Mental Health (NIMH) collaborative treatment outcome study. An earlier study has suggested that Beck's approach may be more effective than use of imipramine alone because of its lower treatment dropout rate and greater reduction in depression level. Patients' pessimistic assumptions and beliefs, the dysfunctional way they construe their world, and such logical distortions as overgeneralization, mislabeling and arbitrary inferences are identified and altered. At the same time, homework that focuses on daily behavior is used to facilitate improvement.

Lewinsohn and colleagues at the University of Oregon have developed a more behavior-oriented approach. Patients keep daily records of their pleasant activities and interpersonal contacts and their thoughts. They are taught to identify those activities or thoughts (or both) that most affect their mood and are then trained to alter them using social learning self-control methods. Patients